UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION 34

ST. MARY HOME Employer [1] and TEAMSTERS LOCAL 671 Petitioner	Case No. 34-RC-2119

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board. Pursuant to Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned. [2] Upon the entire record in this proceeding, I find that: the hearing officer's rulings are free from prejudicial error and are affirmed; the Employer is engaged in commerce within the meaning of the Act, and it will effectuate the purposes of the Act to assert jurisdiction; the labor organization involved claims to represent certain employees of the Employer; and a question affecting commerce exists concerning the representation of certain employees of the Employer.

The Employer operates a 217-bed sub-acute, rehabilitative and long-term skilled medical care facility in West Hartford, Connecticut (herein called the facility). The Petitioner seeks to represent a unit consisting of approximately 35 full-time and regular part-time Licensed Practical Nurse (LPN) and Registered Nurse (RN) charge nurses. There is no history of collective bargaining involving the employees in the petitioned-for unit. The Employer contends that the petition should be dismissed because all the

[1] The Employer's name appears as corrected at the hearing.

[2] The Employer's motion requesting that this case be transferred to the Board for decision is denied.

petitioned-for employees are supervisors within the meaning of Section 2(11) of the Act. For the reasons noted below, I find no merit to the Employer's contention.

I. FACTS

A. Overview of Operations

Primarily responsible for the operation and overall supervision of the facility is Administrator Patty Morse. Reporting to Morse is Assistant Administrator Ann Praxton and Director of Nurses (DON) Mary Frazier, who has overall responsibility for the facility's entire nursing department. Reporting to Frazier is Assistant Director of Nursing (ADON) Karen Cunningham; Staff Development Director Cheryl Dagadue; Human Resource Manager Lee Albrose; Assistant to the DON Peg Chester; Infection Control Nurse Martha Obando; Admissions Clinical Coordinator Sanders; MS Coordinators Jean Tressy and Margaret Genovisi; and ten Nurse Supervisors (also referred to as shift supervisors), who the parties have stipulated to exclude as supervisors within the meaning of Section 2(11) of the Act.

The Employer's facility is divided into the following seven clinical units: four long-term care units (each containing about 30 beds); one secured dementia unit (containing about 30 beds); one intermediate-care unit (containing about 40 beds); and one sub-acute care unit (containing about 24 beds). The facility operates 24 hours a day, 7 days per week, and is staffed by approximately 300 to 350 employees pursuant to the following three-shift per day schedule: 7:00 a.m. to 3:00 p.m. (day shift); 3:00 p.m. to 11:00 p.m. (evening shift); and 11:00 p.m. to 7:00 a.m. (night shift). On weekends the Employer maintains a "Baylor" scheduling program for certain nursing department employees, who work 12-hour shifts (7:00 a.m. to 7:00 p.m. and 7:00 p.m. to 7 a.m.). In addition to the 35 petitioned-for charge nurses, a total of about 160 to 180 certified nurse's aides (CNA) staff the seven clinical units.[3]

Except for the sub-acute unit that has two charge nurses assigned during the hours of 7:00 a.m. to 11:00 p.m., the Employer typically staffs each of its clinical units with a single LPN or RN charge nurse and between 1.5 [4] to 4 CNAs. The record

[3] The record indicates that the CNAs are represented for purposes of collective bargaining by New England Health Care Employees Union, District 1199, SEIU, AFL-CIO.

[4] The .5 designation refers those instances where one CNA will split her shift by providing coverage to two units.

reveals that the total CNA employee complement for the day shift is 22, evening shift is 17 and the night shift is 11. On the day shift weekdays, there are two Nurse Supervisors on duty. At all other times, it appears that only one nurse supervisor is regularly on duty. Unlike the charge nurses, the nurse supervisors must be RNs. It is undisputed that the Nurse Supervisor is responsible for the general oversight of all seven clinical units. Such oversight is accomplished by making regular rounds of the units at least twice per shift to receive resident reports from the charge nurses, and by telephonic contact with the charge nurses throughout the shift. The record is unclear as to the duration of the nurse supervisors' visits to the units. In contrast to the charge nurses, the nurse supervisors do not provide direct resident care, except when the Employer is short staffed and a nurse supervisor fills a charge nurse vacancy.

B. Charge Nurse Duties and Responsibilities

As noted above, the Employer considers all its charge nurses to be supervisors. The Employer proffered the LPN and RN charge nurse job descriptions in support of this contention.[5] In this regard, the LPN charge nurse job description states that the charge nurse reports to nurse managers, supervisors, the ADON and the DON. The RN charge nurse job description states that the RN charge nurse reports to nurse managers, the ADON and the DON.[6] The LPN charge nurse job description contains a list of 39 "job duties and responsibilities". The RN charge nurse job description contains a list of 42 "job descriptions and responsibilities". References to purported supervisory responsibility that are contained in both job descriptions include: "mak[ing] independent clinical decisions regarding resident's needs for medical or nursing care and communicates same to appropriate personnel"; "act[ing] as a liaison between residents, families, physicians, administration and other nursing staff"; "interpret[ing] and implement[ing] policies and procedures"; "participat[ing] in the counseling and disciplinary actions of the staff assigned to the clinical unit"; "conduct[ing] daily rounds … to assure that safe and effective care is being provided by all staff"; and "supervis[ing] and coordinat[ing] resident care provided by certified nursing assistants".

[5] Although the Petitioner's charge nurse witnesses acknowledge receiving job descriptions, they deny these are the job descriptions they received. No other job descriptions were offered into evidence by either party.

[6] The nurse manager position no longer exists and the duties appear to have been assumed by the nurse supervisors.

The primary distinction between the job descriptions is that the RN charge nurse description provides for the performance of expanded patient care duties consistent with the State-mandated RN "scope of practice" guidelines, as well as to fill in as a nurse supervisor as needed. With regard to the latter, the record does not indicate the frequency or duration of such occurrences, if any. All other functions and responsibilities contained in the job descriptions are directly related to resident care, fulfilling licensure requirements and the advancement of the Employer's mission.

In addition to the job descriptions, the Employer proffered the testimony of DON Frazier and ADON Cunningham in support of its contention that the charge nurses are supervisors. According to DON Frazier, charge nurses are responsible for directing the resident care provided by the CNAs on their units and ensuring the progression of their general work flow. Thus, according to Frazier, if a charge nurse determines that proper and timely care has not been provided to a resident, the charge nurse must ensure that the appropriate corrective action is taken by the CNAs, and if a charge nurse fails to initiate appropriate corrective action, they are held accountable. Moreover, she asserts that CNAs who fail to follow the directions of the charge nurse are also held accountable. In support of these contentions, the Employer proffered two disciplinary notices issued to CNAs since November 2003. The first was for "failure to follow a directive from a charge nurse to prevent a resident from potential risk/injury, failure to follow a directive from a nursing supervisor, disrupting unit operations, and failing to reasonably exercise the duties of her job description in a manner that is consistent with the priorities of resident care needs". The second was for "lack of cooperation which compromised 1) resident care [, and] 2) customer service [;] failure to follow directives of the charge nurse[;] potential risk/injury to resident – leaving in bathroom and leaving unit[;] abandonment – (leaving unit at 2:46 p.m. and leaving resident unattended)". These warnings were issued by DON Frazier and Staff Development Director Dagadue, and do not bear the name or signature of any charge nurse. There is no contention or evidence that these or any other forms of discipline were or have been issued by charge nurses, or recommended by charge nurses.[7]

[7] The charge nurses also have no involvement in the processing of grievances pursuant to the collective bargaining agreement covering the CNAs.

ADON Cunningham testified that she recently conferred on the two dayshift charge nurses on the sub-acute unit the authority to send CNAs home if they refuse a direct request of the charge nurse to perform a work assignment. However, the record reveals that when the incident occurred that precipitated her conferring this authority on the two day shift charge nurses, the charge nurses had not taken such action against the CNA who refused a work assignment. Rather, at least one charge nurse sought the guidance of ADON Cunningham, either at the time of the incident or after the fact. Moreover, there is no record evidence that any charge nurse has ever sent a CNA home for work-related reasons. In addition, DON Frazier testified that nurse supervisors would usually handle those situations where CNAs are asked to leave the facility. In this regard, in the event there is a "reportable incident" involving resident abuse by a CNA, State and Federal regulations require the charge nurse to immediately remove the CNA from the site of the incident, and then contact the nurse supervisor, who DON Frazier attributes with "prioritiz[ing] and mak[ing] decisions for the whole building." Thus, it appears that the charge nurse has no discretion in such situations. Moreover, there is no evidence that the charge nurse plays any role in the investigation of the incident, other than as a witness.

In the event that a charge nurse observes a deficiency in a CNA's work performance in the course of the shift, the charge nurse may approach the CNA and attempt to correct the deficiency on an informal basis. If the deficiency or performance problem persists, the charge nurse is expected to bring the matter to the attention of higher management. However, as previously noted, there is no evidence that any CNA has been disciplined as a result of a charge nurse's recommendation.

In furtherance of its contention that charge nurses have been held accountable for the work performance of the CNAs on their unit, the Employer proffered the five-day suspension of a charge nurse in May 2002. The suspension was for failing to adequately monitor the care provided to a resident by the CNAs on the charge nurse's unit, or to take corrective action for the deficient care they provided. However, the circumstances surrounding the suspension involved the alleged failure of the charge nurse to monitor and correct an incident where a resident had been kept belted in a wheelchair for an unacceptable period of time, contrary to the resident's care plan and regulations requiring that residents are provided with the least possible restrictive

environment. While the Petitioner's charge nurse witnesses' uniformly agree that they would expect to be held accountable if they failed to provide appropriate resident care or failed to report a CNA's failure to perform his or her resident-care duties, no specifics were offered as to the means or methods by which they would expect to be held accountable, and whether such accountability would ensue simply because they were themselves culpable for a resident care infraction or had knowledge of a lapse in another employee's resident care obligations and failed to report it. In this regard, the record indicates that CNAs would similarly be held accountable for a failure to report another CNA's known deficiencies in providing proper resident care.

The only other evidence proffered by the Employer in support of its contention that charge nurses may be disciplined for failing to adequately supervise or direct the CNAs in the course of their duties involved an "educational counseling" that it contends was issued to a charge nurse on March 29, 2005 (after the instant petition was filed). However, the documentation clearly shows that the infraction leading to the "educational counseling" was the charge nurse's violation of a regulation and facility policy recognizing that residents have the right not to be involuntarily separated from their rooms. More specifically, the charge nurse, when confronted with a resident deemed to be a fall risk, instructed, against the resident's wishes, that the resident be removed from his/her room and placed at the nurses' station for observation by the charge nurse, instead of ordering some lesser form of intervention.

The Employer also proffered eight charge nurse evaluations from 2002 through 2004 containing notations purportedly reflecting the charge nurses' accountability for failing to adequately direct the care provided by the CNAs. In this regard, the following commentary appears in the "Goals and Areas for Future Development" portion of these appraisal forms: "needs to be more assertive and authoritative in directing the care provided by the CNAs [and] … assure that SMH lunch and break time policies are adhered to"; "become more assertive in delegating tasks to the nursing assistants so that there are fewer interruptions in her workflow"; "needs to … delegate more tasks to ensure she can complete all paperwork by the end of her assigned shift"; "[e]nhance leadership skills by providing clear direction to staff in an effort to improve the quality of care…"; "[a]ssist staff with problem solving and encourage their input in an effort to promote professional development"; "[s]he has taken ownership of her unit in a positive

manner. She guides and supports her CNA in a positive manner"; "[c]ontinue to guide CNA staff to maintain quality of care delivered to residents". Another commentary provided in a 90-day appraisal is that the charge nurse "is beginning to answer the role of supervising and guiding CNAs to administer quality care to residents." The appraisal forms, which are identical to the more recent CNA appraisal forms discussed above, contain 17 areas of competency for which the charge nurse is given a corresponding rating in one of three categories: 1) exceeds expectations; 2) meets expectations; and 3) does not meet expectations. None of the 17 specific areas of competency that are the subject of review in the appraisals reference any purported supervisory duties. Charge nurses have some limited involvement in evaluating CNAs.[8] In this regard, the completion of CNA performance appraisals is not a job requirement of the charge nurses. Rather, this function is principally performed by the nurse supervisors. The evidence indicates, however, that the nurse supervisor may ask for the verbal input of charge nurses, who admittedly work more closely with the CNAs, at the time such appraisals are being written. The information taken into consideration when crafting the CNAs' appraisals also comes from a variety of other sources, including the nurse supervisors' own assessments in addition to those of the residents. The extent to which the nurse supervisors accept or reject the charge nurses' assessments is not contained in the record. Notwithstanding the foregoing, some nurse supervisors signify the charge nurses' input in the process by having them sign the completed CNA appraisal along with the nurse supervisor. Exactly when in the process the charge nurses have signed these appraisals is unclear. The Employer provided only 17 CNA appraisals issuing between 1999 and 2004 that contain the signatures of charge nurses. In fact, 12 of these evaluations were issued by the same nurse supervisor, three were issued by another nurse supervisor and one was issued by a third nurse supervisor. There is no other evidence that any other nurse supervisor has engaged in the practice of having charge nurses sign the CNA appraisal forms. Out of the 17 appraisals, only one, dated May 2003, appears to have been actually completed by a charge nurse, as her signature appears unaccompanied by a nurse supervisor signature. There is no record

[8] Contrary to charge nurse testimony, DON Frazier testified that the charge nurses participate in the CNA appraisal process about 70-75% of the time. Frazier offered internally contradictory testimony, however, by conceding that she "could not swear to [the charge nurses' participation level] under oath."

evidence revealing the impact the appraisals have on such matters as wage increases, tenure, promotions and other employment-related opportunities.

The Employer also proffered the CNA job description in support of the charge nurses alleged supervisory status. This job description states that the CNAs "work under the direction of a licensed nurse", who the testimonial evidence identifies as the charge nurse. It also contains 40 specifically enumerated "job duties and responsibilities", including "Listens to report, obtains assignments and the condition of the residents from the Nurse Manager/Charge Nurse"; "Reports to the Nurse Manager or Charge Nurse when leaving and returning the unit"; and "Promptly reports all changes in the resident's condition or behavior, refusal of care, complaints, accidents or incidents to the Charge Nurse or Nurse Manager".[9]

With regard to the charge nurses' authority to assign and re-assign CNAs, ADON Cunningham testified that charge nurses may change a CNA's established meal and break time, and may re-assign CNAs to different residents and duties as needed. The record does not clearly reflect the method by which such lunch and break times are initially established. It is clear, however, that as resident and overall unit needs fluctuate, the charge nurses are vested with the authority to alter CNAs' break and meal periods. They are further vested with the authority to reassign duties for a resident's care from one CNA's assignment roster to another. In this regard, each CNAs' patient care assignments on a given clinical unit are established by a roster that directs assignments based on the patient's room number. The roster apportions all resident rooms into groupings that align with the number of CNAs assigned to the unit, and these set assignments are rotated among the CNAs every two weeks. Although the charge nurses are not authorized to change the assignment roster itself, they routinely make temporary changes or re-assignments that are the direct result of emergent resident care requirements. For example, a resident's physical or behavioral condition may change unexpectedly in the course of the shift, requiring the realignment of staff to cover for work flow deficiencies, or a resident may require extra help to get to therapy on time or to prepare to leave the facility for a medical appointment. In such

[9] Although the former CNA appraisal forms used prior to 2003 show that one of the elements on which the CNAs were assessed is whether or not they "follow the directions of the charge nurse as appropriate", the appraisal forms in use since that time no longer grade CNAs on this specific job performance category.

circumstances, the charge nurse may reassign certain residents or duties to a different CNA, or may delay a CNAs scheduled lunch or break time until the resident's immediate needs are met. In doing so, the charge nurse primarily attempts to equalize the workload among the CNAs, but may also consider the amenability of particular CNAs to accept additional or different duties, as well as a CNA's prior work experience. Charge nurses may also temporarily reassign CNAs to care for different residents when there is a personality conflict between a given resident and a CNA.[10]

The charge nurses have no authority to reassign CNAs to a different unit, to fill vacancies created by absenteeism, or to approve time off. In additions, call outs are made by the CNAs directly to the nurse supervisors. Charge nurses may not move residents from one room to another.

There is no dispute that the charge nurses are responsible for insuring that resident care plans are properly carried out by the CNAs. According to DON Frazier, charge nurses are responsible for developing the initial care plan for newly admitted residents. However, a charge nurse proffered by the Petitioner testified that the resident care card is filled out by the admissions department, and that she only completes the card with certain "ministerial" information from other departments and external sources. Moreover, ADON Cunningham acknowledged that the initial care plans at the time of admission are pre-printed based upon diagnostic and prescription information, medical history and doctor's orders contained in a report accompanying the resident being admitted.

There also appears to be no dispute that charge nurses have the authority to make nursing judgments regarding resident care, physically assess residents in the event of illness or injury, and make changes to the resident's care plan as long as it is within their "scope of practice" as delineated by various licensing requirements and regulations. Examples of such changes in the care plan that charge nurses can make include canceling rehabilitation sessions if a resident is ill, increasing the number of times a resident is turned in bed, increasing CNA monitoring of residents exhibiting behavioral agitation, ordering urine tests and vital signs be taken by CNAs of residents with suspected infections, and ordering the increase of fluid consumption and the

[10] Petitioner's witnesses testified that assignment changes may only be made by the charge nurses after they have informed the nursing supervisor of such changes.

recording of fluid intake and output by CNAs. Additionally, charge nurses are expected to call for the attending physician's and nurse supervisor's intervention if a resident experiences a serious down turn in their condition. The charge nurse notes these changes to a residents' care plan by recording them on a card, which the CNAs are expected to review at the beginning of each shift. It is the charge nurses responsibility to communicate any changes in a resident's care plan to the CNAs, regardless of whether the changes were made by them or some other health care provider.[11]

As noted above, the Petitioner's witnesses do not dispute that they are responsible for implementing resident care plans and directing the CNAs on their shift in conformity with those plans. However, they assert that these activities require the exercise of very little discretion or independent judgment because various State and Federal regulations, facility-wide policies and rules, and the resident care plans dictate their actions concerning most situations that they are confronted with in the average workday. In this regard, it does not appear that the charge nurses prioritize the CNAs' daily work assignments. Rather, it appears that the CNAs are largely self directed, as their assignments are routine and conform to a "CNA flow sheet" that records each resident's specific needs and sets forth the standards and specific protocols of care to be exercised in meeting those needs. Such flow sheets are not the product of the charge nurses. Also, such routine duties as showering residents are performed in accordance with an established schedule. Thus, one charge nurse witness testified that in a typical week she experiences no need to intervene in any manner with the CNAs' care giving duties. The record also indicates that the Employer maintains a 4-inch thick policy and procedure manual on each unit. However, the record does not reflect the extent to which the charge nurses and CNAs utilize the manual in the course of their average workday.

II. CONCLUSION

It is well established that the burden of proving supervisory status is on the party asserting it. *Kentucky River Community Care v. NLRB*, 532 U.S. 706 (2001). Based upon the foregoing and the record as a whole, I find that the Employer has failed to satisfy its burden of establishing that the charge nurses possess and exercise

[11] One charge nurse testified that she must communicate any changes in the resident's care plan to the nurse supervisor before actually making the changes.

supervisory authority within the meaning of Section 2(11) of the Act. In reaching this conclusion, I note the absence of any evidence that charge nurses have the authority, in the interest of the Employer, to hire, transfer, suspend, layoff, recall, promote, discharge, or reward other employees, or to adjust their grievances, or to effectively recommend any of these actions using independent judgment. Thus, the only remaining basis for finding that the charge nurses are supervisors is their direction and assignment of work performed by the CNAs, and their purported involvement in the discipline and appraisal of CNAs.

The charge nurses' authority to direct the work performed by CNAs and to re-assign CNAs to different residents or job duties in response to resident care requirements, which is done primarily by equalizing employee workload rather than by particular employee abilities or skills, is considered routine in nature and does not confer supervisory status. *Franklin Home Health Agency*, 337 NLRB 826, 830 (2002); *Beverly Health and Rehabilitation Services, Inc.,* 335 NLRB 635, 669-670 (2001); *Clark Machine Corp.*, 308 NLRB 555, 555-556 (1992). Moreover, the charge nurses' authority to direct and re-assign the work performed by the CNAs is circumscribed by regulatory requirements, Employer practices, standard operating procedures, resident care plans, the accessibility of the nurse supervisors should non-routine situations arise, and the largely routine nature of the CNAs' work assignments. *Washington Nursing Home*, 321 NLRB 366, fn. 4 (1996); *Chevron Shipping Co*., 317 NLRB 379, 381 (1995). The charge nurses' direction given to the CNAs regarding changes to resident care plans more closely resembles the sharing of information with co-workers rather than the exercise of discretion or independent judgment. *Beverly Health,* supra at 669*.* The authority to change the CNAs assigned breaks has also been found to be routine and not requiring the exercise of independent judgment. *Loyalhanna Care Center,* 332 NLRB 933, 935 (2000); *Youville Health Care Center, Inc.,* 326 NLRB 495, 496 (1998).

I also note the absence of sufficient evidence showing that the charge nurses "responsibly" direct the work performed by the CNAs. In this regard, although a charge nurses' ability to lead and guide the CNAs may be referenced in the commentary portion of their appraisal, there is no dispute that the appraisal does not rate them with respect to their purported supervisory responsibilities. *Franklin Home Health Agency*, supra, 337 NLRB at 831. Moreover, the two instances of disciplinary action taken

against charge nurses for their alleged failure to properly supervise CNAs appear to be the result of their own lapses in providing proper resident care, rather than failing to insure that the CNAs provided proper resident care.

To the extent that charge nurses are involved in the discipline of CNAs, it appears to be primarily reportorial in nature, *Providence Hospital*, 320 NLRB 717 (1996), particularly in the absence of any evidence that their involvement or recommendations have affected any CNAs job status, pay or tenure. *Franklin Home*, supra at 830; *Ohio Masonic Home*, 295 NLRB 390, 393-394 (1989). Although two CNAs have been disciplined, at least in part, for failing to follow charge nurse directives, there is no evidence that the charge nurses in those instances recommended discipline, or that the CNAs would not have been disciplined for the other infractions referenced in the disciplinary notices in the absence of the failure to follow a charge nurse's directive. Moreover, the charge nurse's authority, pursuant to established policy and regulatory requirements, to remove a CNA from their work area as a result of a resident abuse incident, is not an indicia of supervisory authority. See *Michigan Masonic Home*, 332 NLRB 1409, 1411 fn. 5 (2000); *Beverly Enterprises-Ohio d/b/a Northcrest Nursing Home*, 313 NLRB 491, 497 (1993). The fact that two charge nurses were only recently given the authority to send CNAs home for failing to follow their directives is an indication that such authority did not previously exist, and also indicates that almost all of the charge nurses do not have the authority to send CNAs home for failing to follow their directives. Of equal importance, there is no evidence that any charge nurse has ever sent an employee home for failing to follow a charge nurses' directive. *Michigan Masonic Home*, supra, at 1410. Finally, the charge nurses' input into CNA appraisals appears to be primarily reportorial in nature, *Passavant Health Center*, 284 NLRB 887, 889 (1987), and there is no evidence that the CNAs' appraisals have any impact on their terms and conditions of employment. *Harborside Healthcare, Inc.*, 330 NLRB 1334, 1335 (2000); *Elmhurst Extended Care Facilities, Inc.*, 329 NLRB 535, 536 (1999).

Accordingly, I find that the petitioned-for charge nurses are not supervisors within the meaning of Section 2(11) of the Act.

Based upon the stipulations of the parties and the record as a whole, I find that a unit of full-time and regular part-time RN and LPN charge nurses employed by the Employer at its West Hartford, Connecticut facility may constitute an appropriate unit for

purposes of collective bargaining within the meaning of Section 9(b) of the Act. However, the parties stipulated that the RN charge nurses are professional employees within the meaning of the Act. Because professional and non-professional employees cannot be joined in a single unit without the desires of the professional employees being determined in a single separate vote,[12] I shall direct separate elections in the following voting groups:

> Voting Group (a): All full-time and regular part-time registered nurse (RN) charge nurses employed by the Employer at its West Hartford, Connecticut facility; but excluding LPN charge nurses, all clerical and casual employees, the administrator, assistant administrator, director of nursing, assistant director of nursing, infection control nurse, staff development nurse, adult day care coordinator, wellness coordinator, clinical coordinator, MDS coordinators, shift supervisors and relief shift supervisors, and guards, other professional employees and other supervisors as defined in the Act.
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> Voting Group (b): All full-time and regular part-time licensed practical nurse (LPN) charge nurses employed by the Employer at its West Hartford, Connecticut facility; but excluding registered nurse (RN) charge nurses, all clerical and casual employees, the administrator, assistant administrator, director of nursing, assistant director of nursing, infection control nurse, staff development nurse, adult day care coordinator, wellness coordinator, clinical coordinator, MDS coordinators, shift supervisors and relief shift supervisors, and guards, other professional employees and other supervisors as defined in the Act.

The employees in Voting Group (a) will be asked the following questions on their ballot: (1) Do you desire to be included in the same unit as non-professional employees employed by the Employer at its West Hartford, Connecticut facility for the purpose of collective bargaining? (2) Do you desire to be represented for the purpose of collective bargaining by Teamsters Local 671? If a majority of the employees in Voting Group (a) vote yes to the first question, indicating their desire to be included in a unit with the non-professional employees, they will be so included; and their vote on the second question will then be counted with the votes of the non-professional employees in Voting Group (b) to decide if they will be represented by the Petitioner for the combined bargaining unit (professional and non-professional). If, on the other hand, a majority of the employees in Voting Group (a) do not vote for inclusion with the non-professional

[12] *Sonotone Corporation*, 90 NLRB 1236, 1241 (1950).

employees, they will not be included with the non-professional employees and their votes on the second question will then be separately counted to decide whether they wish to be represented by the Petitioner in a separate unit. With respect to the employees in Voting Group (b), one question shall appear on the ballot: Do you wish to be represented for purposes of collective bargaining by Teamsters Local 671?

In view of the above, my unit determination is based, in part, on the results of the RN charge nurses' vote. Therefore, I now make the following findings in regard to the appropriate unit:

1. If a majority of the RN charge nurses vote for inclusion in a unit with the non-professional employees, I find that the following employees will constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> All full-time and regular part-time registered nurse (RN) and licensed practical nurse (LPN) charge nurses employed by the Employer at its West Hartford, Connecticut facility; but excluding all clerical and casual employees, the administrator, assistant administrator, director of nursing, assistant director of nursing, infection control nurse, staff development nurse, adult day care coordinator, wellness coordinator, clinical coordinator, MDS coordinators, shift supervisors and relief shift supervisors, and guards, other professional employees and other supervisors as defined in the Act.

2. If a majority of the RN charge nurses do not vote for inclusion in a unit with the non-professional employees, I find the following two units to be appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> All full-time and regular part-time registered nurse (RN) charge nurses employed by the Employer at its West Hartford, Connecticut facility; but excluding LPN charge nurses, all clerical and casual employees, the administrator, assistant administrator, director of nursing, assistant director of nursing, infection control nurse, staff development nurse, adult day care coordinator, wellness coordinator, clinical coordinator, MDS coordinators, shift supervisors and relief shift supervisors, and guards, other professional employees and other supervisors as defined in the Act.
>
> All full-time and regular part-time licensed practical nurse (LPN) charge nurses employed by the Employer at its West Hartford, Connecticut facility; but excluding registered nurse (RN) charge nurses, all clerical and casual employees, the administrator, assistant administrator, director of nursing, assistant director of nursing, infection control nurse, staff development nurse, adult day care coordinator, wellness coordinator,

clinical coordinator, MDS coordinators, shift supervisors and relief shift supervisors, and guards, other professional employees and other supervisors as defined in the Act.

DIRECTION OF ELECTION

Elections by secret ballot shall be conducted among the employees in the units found appropriate herein at the time and place set forth in the notices of election to be issued subsequently.

Eligible to vote: those employees in the units who were employed during the payroll period ending immediately preceding the date of this Decision, including employees who did not work during that period because they were in the military services of the United States, ill, on vacation, or temporarily laid off; and employees engaged in an economic strike which commenced less than 12 months before the election date and who retained their status as such during the eligibility period, and their replacements.

Ineligible to vote: employees who have quit or been discharged for cause since the designated payroll period; employees engaged in a strike who have been discharged for cause since the strike's commencement and who have not been rehired or reinstated before the election date: and employees engaged in an economic strike which commenced more than 12 months before the election date and who have been permanently replaced.

To ensure that all eligible employees have the opportunity to be informed of the issues in the exercise of their statutory rights to vote, all parties to the election should have access to a list of voters and their addresses that may be used to communicate with them. *Excelsior Underwear, Inc.*, 156 NLRB 1236 (1966); *NLRB v. Wyman-Gordon Company*, 394 U.S. 759 (1969). Accordingly, it is hereby directed that within seven (7) days of the date of this Decision and Direction of Election, the Employer shall file with the undersigned, separate eligibility lists for each unit containing the *full* names and addresses of all the eligible voters. *North Macon Health Care Facility*, 315 NLRB 359 (1994). The lists must be of sufficiently large type to be clearly legible. The undersigned shall make these lists available to all parties to the election. In order to be timely filed, such lists must be received in the Regional office, 280 Trumbull Street, 21st Floor, Hartford, Connecticut 06103, on or before April 21, 2005. No extension of time

to file these lists shall be granted nor shall the filing of a request for review operate to stay the filing of such lists. Failure to comply with this requirement shall be grounds for setting aside the election whenever proper objections are filed. The list may be submitted by facsimile. To speed preliminary checking and the voting process itself, the names should be alphabetized.

Right to Request Review

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, DC 20570. This request must be received by the Board in Washington by April 28, 2005.

Dated at Hartford, Connecticut, this 14th day of April, 2005.

/s/ Peter B. Hoffman
Peter B. Hoffman, Regional Director
National Labor Relations Board
Region 34